Local 903 IBEW Health Plan – Application for Enrollment

A UnitedHealthcare Company

THIS FORM MUST BE COMPLETED IN ORDER FOR YOU AND YOUR ELIGIBLE DEPENDENTS TO HAVE COVERAGE UNDER THE HEALTH PLAN.

EMPLOYEE NAME (LAST)	(FIRST)	(INITIAL)	EMPLOYEE'S DATE OF BIRTH

MAILING ADDRESS	CITY	STATE	ZIP	GROUP NUMBER
				76-410905

CHECK ONE:	CHECK ONE:	EMPLOYEE'S SOCIAL SECURITY NO.	PHONE NUMBER
☐ MALE ☐ FEMALE	☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED		

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBER

***NOTE:** The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.

LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH MONTH	DAY	YEAR
			☐ HUSBAND ☐ WIFE				
			☐ SON ☐ DAUGHTER				
			☐ SON ☐ DAUGHTER				
			☐ SON ☐ DAUGHTER				
			☐ SON ☐ DAUGHTER				

NATURE OF APPLICATION –

☐ NEW CONTRACT APPLICATION

☐ CANCEL CONTRACT

CHANGE CONTRACT
- ☐ Name Change
- ☐ Address Change
- ☐ Type of Coverage Change
- ☐ Change COB Information

ADD DEPENDENT
- ☐ Add Spouse
- ☐ Add Dependent Child

REMOVE DEPENDENT
- ☐ Remove Spouse
- ☐ Divorce
- ☐ Remove Dependent Child

DATE EVENT OCCURRED (Example: Date of marriage, birth date of child, etc.): _____

COORDINATION OF BENEFITS INFORMATION – If you, your spouse, or your dependents are covered by any *other* group health insurance, please give the following information:

NAME OF CONTRACT HOLDER AND HIS/HER DATE OF BIRTH	GROUP NUMBER	TYPE OF COVERAGE ☐ INDIVIDUAL ☐ FAMILY	NAME OF INSURANCE COMPANY
POLICY, ID, CONTRACT, OR CERTIFICATE NUMBER	**COVERAGE EFFECTIVE DATE**	**EMPLOYER'S NAME**	**EMPLOYER'S STREET ADDRESS/CITY/ STATE/ ZIP**

NAME OF MEMBER ENTITLED TO MEDICARE BENEFITS – Each member covered by or eligible for Medicare must be identified.	MEDICARE COVERAGE TYPE ☐ PART A ☐ PART B	MEDICARE NUMBER AND EFFECTIVE DATE-MM/DD/YY

☐ I waive my rights to benefits and do not wish to enroll.

☐ I am requesting cancellation of my existing benefits as checked above.

☐ I apply for the Local 903 IBEW Health Plan (the "Plan"). I understand that my application is subject to the terms and conditions of the Plan and the agreement between the Plan and UMR. I understand that coverage is subject to the eligibility rules and plan of benefits as stated in the Local 903 IBEW Health Plan Summary Plan Description. I agree to provide all information needed to administer the Plan and agree to abide by all rules. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law. I understand that coverage under the Local 903 IBEW Health Plan will not start until my application is accepted by evidence of issuing an Identification Card or other written notice. I agree to notify the Plan Manager, Alabama Administrators, if an Eligible Dependent has a change in status and especially if a dependent is no longer a dependent due to a divorce. I agree that benefits may be paid direct to providers of service and such payment will release the Plan of its benefit obligation. I authorize my doctor, hospital, or anyone else to give all medical records for anyone covered under my coverage to the Claims Administrator for the operation of the Plan including determination of eligibility and benefits. I agree to cooperate with the Claims Administrator and provide information required to administer the Plan, pay claims, coordinate benefits with other coverage, subrogate against another responsible party, or recover benefits paid in error. Everything in this application is true.

X _____ **X** _____

SIGNATURE OF EMPLOYEE **DATE SIGNED**

Local 903 IBEW Health Plan
1717 Old Shell Road
Mobile, AL 36604

Plan Manager: Alabama Administrators
Phone: (800) 221-7025
Fax: (251) 478-0203